



Questions from the RITTS – Spinal Cord Injury Referral

Please note that shaded boxes are mandatory.

Patient name	Date
Type of rehabilitation service	Sending physician
Receiving facility	Receiving physician

What is the primary diagnosis? <input type="checkbox"/> Spinal Cord injury – Complete <input type="checkbox"/> Spinal Cord injury – Incomplete <input type="checkbox"/> Other ☞	If you selected "Other", please specify:
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What is the secondary diagnosis / Other Medical Co-Morbidities?

Is the secondary diagnosis oncology related? <input type="checkbox"/> Yes ☞ <input type="checkbox"/> No	If you answered "Yes," is the patient aware of their prognosis? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If you answered "Yes," what is the prognosis?

What is the major reason for the referral? <input type="checkbox"/> Contractures <input type="checkbox"/> Deconditioning syndrome <input type="checkbox"/> Equipment needs <input type="checkbox"/> Housing needs <input type="checkbox"/> Mobility issues <input type="checkbox"/> Pain management	<input type="checkbox"/> Pressure sores <input type="checkbox"/> Psycho/social issues <input type="checkbox"/> Seating needs <input type="checkbox"/> Spasm management <input type="checkbox"/> Transfers (and Mobility Training) <input type="checkbox"/> Other ☞	If you selected "Other," please specify:
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Are there swallowing issues? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are there nutritional issues? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If the individual has any of the following infectious organisms, please specify: <input type="checkbox"/> C-dif <input type="checkbox"/> MRSA <input type="checkbox"/> TB	<input type="checkbox"/> VRE <input type="checkbox"/> Other ☞ <input type="checkbox"/> None	If you selected 'Other,' please specify:
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Please input the results for the following tests / investigations:	Completed	In Progress	N / A
CAT Scan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electrocardiogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MRI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doppler and result	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other ☞	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you selected "Other," please specify:			



Rehabilitation Integrated Transition Tracking System (RITTS)

<p>Are there any allergies?</p> <p><input type="checkbox"/> Yes ☞</p> <p><input type="checkbox"/> No</p>	<p>If you selected 'Yes,' please specify:</p>	
<p>What was the date of onset / surgery? (yyyy-mm-dd)</p>		
<p>What was the cause of the injury/surgery?</p>		
<p>Was there a head injury?</p> <p><input type="checkbox"/> Yes ☞</p> <p><input type="checkbox"/> No</p>	<p>If you selected "Yes," was there a loss of consciousness?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	
<p>Is there a sitting tolerance of 1 hour twice a day?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>		
<p>Please list medications:</p>		
<p>Are there respiratory needs?</p> <p><input type="checkbox"/> Yes ☞</p> <p><input type="checkbox"/> No</p>	<p>If you selected "Yes," is the patient on a mechanical ventilator?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	
	<p>If you selected "Yes" and if they have a tracheotomy, how often is suction needed in a 24-hour period?</p>	
	<p>If you selected "Yes," are there chest complications/infections?</p> <p><input type="checkbox"/> Yes ☞</p> <p><input type="checkbox"/> No</p>	<p>If you selected "Yes," what is the date of last infection? (yyyy-mm-dd)</p>
	<p>If you selected "Yes," is the chest X-Ray stable or improving?</p> <p><input type="checkbox"/> Stable</p> <p><input type="checkbox"/> Improving</p>	
	<p>If you selected "Yes," is peak cough flow greater than 200 lpm?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	



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	<p>If there are respiratory needs, what is the oxygen saturation while on room air?</p> <p><input type="checkbox"/> Equal to 95%</p> <p><input type="checkbox"/> Greater than 95%</p> <p><input type="checkbox"/> Less than 95%</p>
	<p>If there are respiratory needs, is there sleep disordered breathing?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>Are there patient identified goals?</p> <p><input type="checkbox"/> Yes ☞</p> <p><input type="checkbox"/> No</p>	<p>If you selected "Yes," please list:</p>
<p>Select one of the following designated discharge environments:</p> <p><input type="checkbox"/> Complex care</p> <p><input type="checkbox"/> Continuing care</p> <p><input type="checkbox"/> Home</p> <p><input type="checkbox"/> Long term care</p>	<p>If you selected "Other," please indicate:</p> <p><input type="checkbox"/> Not Yet Explored</p> <p><input type="checkbox"/> Nursing Home</p> <p><input type="checkbox"/> Retirement Home</p> <p><input type="checkbox"/> Other ☞</p>
<p>Other information and/or investigations and tests to follow via fax or mail. (A facility's contact information can be found using the Find a Rehab Service tab.)</p>	

Please forward all pertinent investigative reports and consult notes.